HARM REDUCTION INTERNATIONAL REPORTS

Harm reduction investment in the European Union

Current spending, challenges and successes

Catherine Cook
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HARM REDUCTION INTERNATIONAL

'Harm Reduction Works!' is a two-year project funded by the European Commission and coordinated jointly by the Eurasian Harm Reduction Network and Harm Reduction International. The project aims to increase the knowledge and capacity of civil society to advocate for strategic investment in rights-based harm reduction programming across the European Union.

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Contents

Key Terms

AIDS	Acquired Immune Deficiency Syndrome
ARAS	Romanian Association Against AIDS
CSO	Civil Society Organisation
DCR	Drug Consumption Rooms
EHRN	Eurasian Harm Reduction Network
EMCDDA	European Monitoring Centre on Drugs and Drug Addiction
ENSRF	European National Strategic Reference Framework
ESF	European Structural Funds
EuroHRN	European Harm Reduction Network
GCDPC	Czech Republic Government Council for Drug Policy Coordination
GDP	Gross Domestic Product
GIZ	German Society for International Cooperation
HIV	Human Immunodeficiency Virus
HRI	Harm Reduction International
LEA	Italian Livelli Essenziali di Assistenza (the list of essential services that Italian regions must provide)
NBDP	Polish National Bureau for Drug Prevention
NGO	Non-Governmental Organisation
NIHD	Estonian National Institute of Health Development
NPS	New Psychoactive Substances
NSP	Needle and Syringe Programmes
OKANA	Greek Agency Against Drugs
OST	Opioid Substitution Therapy
SICAD	Serviço de Intervenção em Comportamentos Aditivos e Dependências (the government department responsible for drugs in Portugal)
STI	Sexually Transmitted Infection
TB	Tuberculosis
THN	Take-home Naloxone
UNAIDS	Joint United Nations Programme on HIV/AIDS

Introduction

An unequivocal evidence base shows that harm reduction works. In countries all around the world, implementing and scaling up harm reduction interventions such as needle and syringe programmes and the provision of opioid substitution therapy has been shown to prevent infections, save lives and to reduce crime.[1, 2] Importantly in the current financial climate, harm reduction approaches are also proven to be both cost-effective and cost-saving for those governments that invest in them.[3, 4] Supportive evidence for the effectiveness and cost-effectiveness of take-home naloxone programmes[5] and drug consumption rooms[6] is also clear from those countries where they are in place, leading several governments to consider adding these approaches to their national harm reduction programmes in recent years.

Europe is the birthplace of harm reduction and is the region where the successes of this approach in averting and reducing HIV epidemics among people who inject drugs can be most plainly seen. However, even in some of these long-term implementing countries where harm reduction is integrated into national health systems, economic crises and political pressure have affected the provision and reach of services. In other countries, harm reduction funding has been severely cut, resulting in sharp increases in HIV infections among people who inject drugs. In others still, where international donor funds have ended or dramatically reduced, some governments have increased domestic support for harm reduction, but a notable few have not. In these worst cases, harm reduction services have been left in a state of emergency.

This report will present the findings of Harm Reduction International's research into harm reduction investment in EU member states, structured around four key areas: harm reduction coverage; government investment in harm reduction; transparency of spending data; and civil society representatives' views on sustainability of funding. Compiled by HRI, the findings are based on contributions from civil society across the region and address the successes and challenges faced in ensuring sustainable harm reduction responses in EU member states.

Methodology:[a]

HRI collaborated with researchers in seven EU countries (Czech Republic, Greece, Italy, Estonia, Portugal, Hungary and Lithuania) to gather data on national investment in key harm reduction interventions, to compile survey responses in consultation with key stakeholders and to complete a case study on harm reduction funding in their respective countries.[b] Within the report these countries are highlighted as case study countries. In the remaining EU member states, HRI approached civil society contacts with an online survey,[c] initially providing a three-week window for responses to be submitted via SurveyMonkey. Most contacts were members of the European Harm Reduction Network (EuroHRN) and/or the Eurasian Harm Reduction Network (EHRN) and had some involvement in both harm reduction service provision and national or regional advocacy.

Limitations:

Unfortunately, HRI received no survey responses from Austria, Denmark, French Belgium, Latvia, Luxembourg, Slovakia, Slovenia, Spain or Romania, despite additional time being given and reassurance that as a new area of study for most, data gaps were to be expected and any insights would be useful. In the case of Romania, however, there was enough data available from existing sources to provide a picture of the harm reduction funding situation without a survey response. The limited response rate is likely to be indicative of time limitations facing overburdened harm reduction service providers, as well as unfamiliarity with the subject matter leaving some reluctant to respond. Several contacts indicated that while this was an important area of study for them, they did not have access to the right information or did not have the time to spare to gather information. Therefore, the report cannot provide a complete picture of the harm reduction funding situation with the European Union. However, there are many valuable insights into the challenges and successes for sustainable harm reduction funding in those countries included in the report.

a For full details on the research methodology please refer to the HRI website: www.hri.global/harmreductionworks.
b For national case studies please refer to the HRI website: www.hri.global/harmreductionworks.
c HRI was unable to identify contacts to send the survey to in Croatia, Cyprus and Malta. In Belgium, the survey was sent to two contacts, representing Flemish and French Belgium respectively.

Guide to country ranking system:

HRI developed a simple set of criteria to categorise the harm reduction funding situations in EU member states (see Table 1). Based on research undertaken within the Harm Reduction Works! project, countries have been grouped using a traffic light system as either red, amber or green on each criterion. This traffic light system is useful to provide an at-a-glance indication of the health of harm reduction funding in a country. However, detailed justifications of each ranking decision should be referred to for further insight into the national context.[d] Within the report, country information will be presented using the four criteria below as sub-headings, starting with those countries categorised as mainly red and ending with those mainly green.

Table 1: Criteria for establishing national harm reduction funding situation

Factor	Green	Amber	Red
Harm reduction coverage	Both NSP and OST operating at recommended coverage levels	Either NSP or OST operating at recommended coverage levels	Neither NSP or OST operating at recommended coverage levels
Transparency of spending data	Spending information routinely collected and made available in a transparent manner	Partial spending information available	Spending information unavailable
Government investment in harm reduction	Overall government investment is high and government provides over 90% of harm reduction funding	Government investment is moderate, either proportionally (e.g. government provides between 50% - 90% of HR funding) or as an overall amount	Government investment is low, either proportionally (e.g. government provides less than 50% of harm reduction funding) or as an overall amount
Civil society representatives' view on sustainability of funding	Funding judged to be secure for next 5 years	Some uncertainty around funding levels and anticipated reductions in the next five years	Funding for harm reduction extremely low, or serious funding cuts anticipated in the next five years

d It should be noted that ranking decisions, particularly where researchers were not employed to carry out in-depth research, were somewhat dependent on individual respondents' proximity to the relevant subject matter and available data. Harm reduction coverage information for each country is summarised in a short table. For more detailed analysis of coverage with full references, please refer to HRI's website: www.hri.global/harmreductionworks/.

Harm reduction investment in the European Union

There is a funding crisis for harm reduction within the European Union, albeit a crisis confined to specific states. Bulgaria, Romania, Poland, Greece and Hungary are ranked red on two or more criteria within this report, indicating a poor state of funding for harm reduction. The findings highlighted three factors that underpin their situations; namely austerity, international donor retreat and poor political support for harm reduction. These factors of course overlap and interact with each other. In Bulgaria and Romania, where until recently harm reduction had been predominantly supported through international donor funding, the investment gap left behind and the absence of increased government support to cover this has crippled service provision.

Since the international financial crisis in 2008, the majority of European governments have imposed austerity measures. There is evidence of these measures having a detrimental effect on harm reduction funding in Greece, where national investment in OST in 2015 is half the level of investment at its peak in 2012. Even in Portugal, where harm reduction has political support, the government has preserved existing harm reduction investment to the same levels, but has not increased it to reflect the impact of austerity in increasing living costs. This has resulted in a streamlining of services and an overburdening of harm reduction workers. Elsewhere, the impact of austerity has been buffered somewhat, particularly in those countries where political will for harm reduction is strong.

The European Union is home to some of the best examples of sustainable harm reduction funding, including several states that enjoy well-funded politically supported harm reduction programmes that were ranked mostly green within this research. However, the situation in some EU states is as challenging as in other parts of the world. In general, the state of harm reduction funding is better in countries in the Western part of the European Union, but this is not uniform. Greece for example faces significant funding challenges. There are also examples of good practice from the East, such as Estonia and the Czech Republic. Findings from Belgium, Finland, France, Germany and the Netherlands all highlighted good practices and strategies that could be useful to inform change in other parts of the region. Some common factors that tend to be in place in these countries include political support for harm reduction as a practical, effective and cost-effective approach, supportive laws and policies for harm reduction and strong and supported civil society. Importantly, the political support came not just from national government, but also decision-makers at regional and municipality levels, which yielded significant investments in service delivery. It was in these countries where a wider spectrum of harm reduction interventions were financially supported by national governments including drug consumption rooms, heroin-assisted treatment and take home naloxone programmes. However, even in these countries, this research highlighted gaps and areas where governments could improve the efficiency of their investments. To do this effectively, however, a clear understanding of current investment is necessary.

No country achieved a green ranking on transparency of harm reduction spending. Even in countries with well-funded harm reduction programmes that were achieving high coverage, it was challenging for civil society representatives and researchers to establish the level of harm reduction investment with any level of accuracy. While some countries had carried out dedicated research on this in the context of wider drug policy expenditure, this was not routine and did not reach down to the level of intervention. Some countries had national mechanisms in place to track certain health or drug policy-related expenditure but did not isolate harm reduction spending. Commonly, the spending related to the provision of OST was the most difficult to extricate from wider health care provision spending, as this service was integrated into the national health systems and was delivered alongside numerous other services in an outpatient healthcare setting. In several countries the harm reduction funding allocations were devolved to the regional or municipal level, which resulted in wide variation in funding levels across the country. Where there was no mechanism for centrally tracking regional investment and aggregating this, the process of establishing a national picture of harm reduction funding in these countries was, as our researcher in Italy described, 'truly detective work'.[7]

This knowledge gap on harm reduction funding threatens the ability of governments to ensure the success of their national programmes. It should not be so challenging to establish what is being spent on crucial harm reduction interventions. This is necessary information for strategic budget decision making to ensure that ever-reducing funding is invested where it is most needed and will have the most impact. This project provided an important opportunity for harm reduction advocates in

seven countries to study harm reduction investment in a more in-depth fashion than they had been able to before. This has informed national advocacy efforts and it has initiated dialogue between civil society and decision-makers on improvements that could be made to the current funding situation in several countries.

> *'This study allowed several stakeholders to understand that there is a real possibility to enhance the total amount of money available for harm reduction very considerably if dialogue between funders and harm reduction projects gets improved. This type of work is now beginning to take place.'* - Marta Pinto, Harm Reduction Works! researcher, Portugal

According to the findings of this research, the future sustainability of harm reduction funding in Europe ranges from fairly certain to extremely insecure. Civil society in several countries shared fears that rapid increases in HIV infection rates among people who inject drugs were likely or even imminent due to limited harm reduction and, in some cases, a rise in amphetamine use and associated increased injecting. In the Czech Republic, oral methamphetamine capsules are being distributed to give people an alternative to injecting methamphetamine. Elsewhere, it was reported that harm reduction services traditionally oriented towards people who inject opioids were being required to adapt their services to new drug use trends. In several places, civil society representatives lamented that this adaptive flexibility was not possible due to limited funding and already stretched service providers. This research highlights several actions that could increase the sustainability of harm reduction funding within the European Union.

Recommendations

National authorities

1. At the 2016 UN General Assembly Special Session on Drugs, all EU member states committed to reducing the adverse public health and social consequences of drug use, endorsing four harm reduction interventions – "medication-assisted therapy, injecting equipment programmes and antiretroviral treatment", alongside Naloxone for the treatment of overdose. The previous year they also committed to ending AIDS by 2030 under target 3.3 of the UN Sustainable Development Goals. In order to fulfil these international obligations, national governments must ensure sustainable funding for harm reduction.

2. Moreover, under international human rights law, states should not take deliberately retrogressive measures that deprive people of rights they previously enjoyed, including reducing health spending or cutting health services. This applies to countries that are reducing budgets through austerity measures. With both increased drug use and HIV incidence reported in Europe during periods of economic hardship,[8] governments should ensure that harm reduction funding is not reduced to the extent where this has an impact on service provision. Indeed, in the cases of Greece and Romania, the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) has explicitly advised the respective governments to protect harm reduction funding from austerity measures.[9]

3. Also in the context of austerity, governments should undertake cost-effectiveness studies into their drug policy spending and redirect funds from drug enforcement to harm reduction. Across the region, investment in ineffective and often repressive drug enforcement measures dramatically outweighs spending on health and harm reduction. Data modelling by Harm Reduction International and the Burnett Institute has shown that a redirection of 7.5% of funds globally would have the potential to virtually end AIDS among people who inject drugs by 2030.[10]

4. Finally, the knowledge gap on harm reduction funding threatens governments' ability to ensure success. It is extremely challenging to establish current harm reduction spending levels in European countries, where harm reduction is often heavily integrated into health systems. National authorities should make harm reduction spending information more transparent and should systematically monitor it in order to inform budget allocations and to ensure the efficiency of investment. Options to integrate indicators on harm reduction spending into existing monitoring mechanisms should be explored.

These recommendations echo the recent Malta Declaration on HIV/AIDS, which called on EU member states to "ensure high-impact, evidence-based and cost-effective combination prevention measures targeting priority groups including ... effective, comprehensive and accessible harm reduction services for people who use drugs and their sexual partners".[11]

The European institutions

1. This research highlighted that five EU countries - Bulgaria, Greece, Romania, Hungary and Poland - are experiencing funding crises for harm reduction. Most of these countries are now ineligible for Global Fund grants, or will soon become ineligible, while domestic investment is low and rates of injecting drug use, HIV and hepatitis C are high, or increasing. The European Commission should create a time-bound emergency fund to keep services in operation in such countries to avert public health emergencies.

2. With civil society organisations (CSOs) being the sole providers of harm reduction in a number of these countries, the European Commission should ensure that any future emergency fund be accessible to CSOs and avoid cumbersome application processes with very low success rates.[12] One suggestion would be a grant distribution and management system modelled on that used by the Norway NGO Fund grants (EEA) where local civil society plays a key role in managing the grants.[13] Any emergency harm reduction grants should also be exempt from the European Union standard co-funding expectations.

3. Beyond emergency funding, the European Commission should lead the development of a new HIV Strategy and Action Plan with a strong emphasis on ensuring the sustainability of harm reduction services. The next EU Action Plan on Drugs, to cover the period 2017-2020, should support these efforts. The Directorate Generals of Health and Justice need to collaborate more effectively to ensure a sustainable harm reduction response within the EU.

4. Finally, as the European monitoring body on the Drugs, the EMCDDA and its network of National Reitox Focal Points should consider including specific indicators on harm reduction investment within regular data collection requirements. This could be the mechanism to systematically track spending and to flag any changes in a timely manner to alert the European Commission that a country may require outside assistance to avoid a public health emergency.

5. Once again these recommendations echo The Malta Declaration on HIV/AIDS which invites the European Commission to use the EU Health Programme to help support public health measures required to be taken by Member States, and urges them to provide political support and financing for global and regional efforts to end AIDS by 2030.

The Global Fund for AIDS, TB and Malaria

1. The Global Fund for AIDS, TB and Malaria must do more to support and encourage governments in those EU states where it is withdrawing harm reduction funding to transition to national funding. Responsible transition is paramount to the sustainability of harm reduction (and other) programmes, particularly where there is limited political support.

2. The Global Fund's NGO rule, which provides for directly funding NGOs in upper-middle income countries that fit the Global Fund's eligibility criteria, must remain an option for countries where government investment in programmes is not forthcoming. Applications from civil society organisations in Hungary and Bulgaria have been declined on the basis that there was not enough proof of political barriers to funding harm reduction. The Global Fund should better define what is meant by political barriers and what constitutes proof that these are insurmountable enough to warrant Global Fund support.

Table 2: Harm reduction funding in the European Union at a glance

Country	Harm reduction coverage	Transparency of spending data	Government investment in harm reduction	Civil society view on the sustainability of funding
Bulgaria				
Romania				
Poland				
Hungary				
Greece				
Lithuania				
Italy				
Sweden				
Czech Republic				
Portugal				
Finland				
Estonia				
UK				
Ireland	not known			
Belgium				
France				
Germany				
The Netherlands				

Bulgaria - A snapshot of harm reduction funding

Harm reduction coverage

People who inject drugs	19,000
NSP	Low coverage – 10 sites delivered the equivalent of 59 syringes per person injecting drugs in 2013.
OST	Low coverage – 3,563 clients receiving OST (mainly methadone) in 2013
DCR	Not available
Prison harm reduction	OST is available in one prison in Sofia for those receiving OST prior to incarceration. No NSP available
Take home naloxone	No take-home naloxone programmes

Transparency of spending data

Information on current investment in harm reduction interventions in Bulgaria is not made public.[14] Attempts to establish the actual spending on OST, for example, have proved challenging. In-depth research would be required to establish the total national investment in harm reduction as, while some spending reports are likely to be held by the Ministry of Health and the Global Fund, this information is not accessible or likely to be disaggregated by intervention.

Government investment in harm reduction

The Bulgarian government funds approximately 73% of the national HIV response, including covering the cost of HIV testing and treatment.[12] They also partially fund the provision of OST, covering the cost of about one-third of OST clients in the country.[15] These treatment slots have long waiting lists and are primarily filled by people living with HIV and pregnant women.[15] The remaining two-thirds of OST clients partially or wholly pay for their own treatment with the costs varying depending on the provider. As the free and less expensive treatment slots are often full, providers can charge a premium for this treatment. Two-thirds of people receiving OST in the country pay a monthly fee amounting to at least one-third of the minimum national wage. Those receiving buprenorphine and a small number receiving Substitol also pay for their medication costs.[12]

Since 2003, harm reduction programmes have been primarily supported through a Global Fund grant to the Bulgarian Ministry of Health for the 'Prevention and Control of HIV/AIDS'. While technically still eligible for Global Fund funds under the NGO rule,[e] in 2014, the Global Fund did not allocate HIV funds to Bulgaria as they judged the evidence of political barriers to implementing HIV prevention activities to be insufficient.[12] A no-cost extension was granted until May 2017, allowing previously unspent funds to be used, after which Bulgaria's Global Fund HIV grant will be due to close. It is hoped that harm reduction programmes will then be funded by the government, although there has been no confirmation of this to date.

Decreasing international assistance for the HIV response in Bulgaria has been met with increased investment from the Bulgarian government. In 2013, domestic support was almost three times that of the international support (USD 8.7 million versus USD 3.1 million respectively).[16] However, the gap that the Global Fund's departure is leaving for harm reduction funding has not been covered by the government. NSP, peer education and outreach will be amongst the interventions most affected by this reduction in funding. Civil society organisations report that cuts in Global Fund support in late 2015 led two of the ten NSPs to cease operations. Of the remaining eight programmes, six have been able to continue their services until May 2017.[15] NGO Iniciativa za Zdrave estimate that the budget required to keep NSPs operating at 2014 levels is about USD 425,000, just 5% of total government investment in the national HIV response.[15] While harm reduction is within the national strategy, this political commitment in writing has not yet been met with finances.[15] There remains no clear plan for a transition from international donor support to a state-supported national harm reduction programme.[15]

e The NGO rule allows NGOs in countries with political barriers to service provision to apply for Global Fund funding without approval of the County Coordinating Mechanism.

Civil society view on sustainability of funding

In 2014, the threat of Global Fund departure galvanised civil society action, with collective lobbying, press conferences, parliamentary actions and a manifesto signed by over 30 NGOs to fight for HIV prevention activities to continue.

When asked how harm reduction services could be made sustainable in the future, civil society organisations pointed to the Bulgarian Health Act, which states that 1% of the government tax on alcohol and cigarette sales should be used to fund prevention programmes relating to tobacco, alcohol and drugs. Currently, this funding is managed by Ministry of Finance but it is not clear where funds are invested. Civil society have been calling for this tax to be directed towards harm reduction programmes and it is believed that the amount available would be substantial enough to cover the gap left by international donor retreat.[15]

In 2016, harm reduction advocates report that the low prioritisation of harm reduction by the Bulgarian government continues to be the primary barrier to the continuation of harm reduction in Bulgaria. If this remains the case, domestic support is unlikely to cover the gap left behind by the exiting Global Fund.

As recommended by the Eurasian Harm Reduction Network in 2015, the development of a clear and realistic plan to transition from international donor funding to state support for harm reduction is essential. EHRN suggest that the Ministry of Health should work with the Global Fund to establish the transition plan, ensuring civil society engagement and integration with the new National Program for Prevention and Control of HIV/AIDS and STI 2016-2020. They also emphasise the need to ensure NGO funding mechanisms are working optimally, and to garner cross-ministerial support for harm reduction.[12]

Until such a plan exists and can be implemented, the Global Fund should reconsider the case of Bulgaria and deem the country eligible for HIV funding under the NGO rule.[f] This would ensure that harm reduction services can continue and that the gains made with Global Fund support over the past decade are not lost.

f For more details on the NGO rule, see the Global Fund Eligibility List 2017 available here: https://www.theglobalfund.org/media/5601/core_eligiblecountries2017_list_en.pdf and the Global Fund Eligibility Policy available here: https://www.theglobalfund.org/media/4227/bm35_06-eligibility_policy_en.pdf

Romania - A snapshot of harm reduction funding

Harm reduction coverage

People who inject drugs	19,265
NSP	Likely low coverage – 2 NSP in 5 fixed locations in Bucharest
OST	Low coverage – 2014 estimates ranging from 8.8% to 19.4% of people use opiates receiving OST
DCR	Not available
Prison harm reduction	In theory NSP in 8 prisons but programme not functional
Take home naloxone	No take-home naloxone programmes

Transparency of spending data

Establishing current spending on harm reduction in Romania is challenging as this data is not routinely collected or made public. In the Eurasian Harm Reduction Network's recent analysis of the country's readiness to transition to a state-funded response, they note 'The government has not undertaken a costing of each component of the harm reduction program and data from NGOs is sporadic and not recognized by the Government.'[17]

Government investment in harm reduction

Harm reduction in Romania has been predominantly funded by international donor assistance. Global Fund support for the national HIV response in Romania ended in 2010. With no transition plan in place, this resulted in a collapse of NSP services in particular and a sharp increase in HIV infection among people who inject drugs followed.[17-19] Since 2010, various funding sources have supported harm reduction services, including structural funding from the European Union allocated to harm reduction services between 2011 and 2014.[17] Additionally from 2014-2016, the Ministry of Health received funding from the Norwegian Financial Mechanism to strengthen HIV, hepatitis B and C prevention which also supported NSP delivery. A Global Fund TB grant managed by Romanian Angel Appeal runs from 2015-2017 and includes some support for harm reduction. This grant has led to improved outreach and TB integration into the remaining NSP services in Bucharest.

While committed in policy through the new National Strategy on Narcotics 2013-2020 and associated Action Plan 2013-2016,[20] there is no budget attached to this work and, overall, the government has provided little financial support for harm reduction. Following protest action in 2013, the Ministry of Health provided some financial support to NSP for a limited period. The National anti-Drug Agency did also procure needles and syringes but there are reports that these were of such poor quality that people refused to use them until no others were available.[21] In recent years, the Bucharest municipality has supported ARAS to deliver NSP but this funding has been limited and not sufficient to cover all costs.[22] In real terms, government investment in harm reduction has been minimal. It is estimated that less than 1% of the Government's HIV budget goes towards HIV prevention,[23] when UNAIDS recommends this should amount to 25% for an effective national HIV programme.

Sustainability of harm reduction funding

Harm reduction in Romania has been under serious threat since the Global Fund's departure in 2010. There followed a spike in HIV infections among people who inject drugs which caused international concern and civil society action. This galvanised some government investment, but the majority of support came from external donors, briefly leading to an increase in harm reduction service coverage. But in 2016, service coverage had decreased again, leading civil society organisations to warn of the likelihood of more rapid increases in HIV among people who inject drugs.

In November 2016, Romanian civil society organisations issued a joint statement to the Global Fund Board in advance of the Thirty-Sixth Meeting calling for the country's eligibility for HIV funding under the "NGO rule"[g] to be considered and urging the Board to prevent Romania being allocated no funds for the HIV component for the period 2017-2019.[h]

Romanian NGOs are in theory eligible to apply for Global Fund funding for HIV under the "NGO rule", but evidence of political barriers to service delivery was deemed insufficient by the Global Fund Board. The Eurasian Harm Reduction Network recently assessed Romania's readiness to transition from international donor assistance to state support using their Transition Readiness Assessment Tool. Romania scored 31% indicating a low level of preparedness, particularly in the areas of governance and finance. They highlighted that 'no sustainability plan has been drafted; no institutionalised governance mechanism for the HIV/AIDS sector is envisaged; and there is no formal mechanism by which NGOs can receive government funding'. They concluded that there is no government willingness to invest in harm reduction at this time.[17]

g The NGO rule allows NGOs in countries no longer eligible for a Global Fund grant to apply for funds when there are considerable barriers to funds being provided by the government.
h See full text of the letter and list of signatories here: http://drogriporter.hu/en/romania_letter; more info here: http://www.harm-reduction.org/blog/romania-and-other-middle-income-countries-%E2%80%93-lost-transition-and-lack-solidarity

Poland - A snapshot of harm reduction funding

Harm reduction coverage

People who inject drugs	15,119 (10,444–19,794)
NSP	Low coverage – 167,119 syringes distributed in 2014[24]
OST	Low coverage – in 2014, there were 2,586 clients receiving OST
DCR	Not available
Prison harm reduction	Limited OST provision in 23 prisons with 140 prisoners receiving OST in 2014
Take home naloxone	No take-home naloxone programmes

Transparency of spending data

There is no mechanism for easily identifying harm reduction expenditure in Poland. Harm reduction allocations are made both at the national level by the National Bureau for Drug Prevention (NBDP) and at the provincial level by municipalities. To establish the amount invested in harm reduction provision in Poland would require dedicated research.

There was an effort made to estimate the funding for NGOs with drug demand reduction programmes in 2012, including harm reduction.[25] Then in 2013, data was collected from municipal governments on their drug-related expenditure.[25] However, these processes did not isolate harm reduction costs within them so they do not provide insight into harm reduction spending.

Government investment in harm reduction

The government is the main source of harm reduction funding in Poland. Civil society representatives could not estimate expenditure on NSP in Poland. At the national level, the NBDP holds a budget for prevention, harm reduction and rehabilitation. In 2014, the NBDP allocated around €170,000 for harm reduction programmes, some of which supported NSP.[26, 27] However, civil society state that very often these funds are directed towards programmes prioritising clients becoming abstinent.[27] There is also funding from the Ministry of Health for the National AIDS Centre, but this does not currently support harm reduction programmes or other drug-related initiatives.

At the local level, the main city within each province can allocate funds from their municipal budgets to harm reduction initiatives. The extent to which harm reduction receives funds at the municipal level is determined by the local government support for harm reduction approaches, but as this is not tracked, it is difficult to know what levels of funding are in place in each Polish county. EMCDDA report that the NBDP co-financed twelve projects for people who use drugs, while local governments contributed to the funding of eighteen harm reduction programmes.[25] Funding for safer nightlife initiatives is available but is most often spent on drug prevention programmes, rather than harm reduction.[27]

The provision of OST is fully funded by the National Government Health Fund. The most recent spending data suggests that in 2012, the government invested around €4,750,000 in OST provision.

EMCDDA report an estimate of public drug-related expenditure to have been €25,805,008 in 2014, based on spending data from NGOs and local government. This represents 0.01% of gross domestic product (GDP) in Poland.[25] Harm reduction spending is likely a small proportion of this figure, as it would also include drug prevention initiatives, abstinence-based programmes and more. It is also reported that the overall amount invested in drug-related initiatives is likely to have decreased in recent years.[25, 27]

Sustainability of harm reduction funding

While there are no accurate estimates of NSP funding in Poland, it is reported that service provision has decreased due to reduced funding in recent years.[25, 27] Harm reduction is included in The National Programme for Counteracting Drug Addiction, which is a part of the National Health Programme 2016-2020 accepted in 2016 by the government. Harm reduction receives greater emphasis in this document than in the previous plan which ran from 2011 – 2016, with the interventions of NSP and OST explicitly named.

Civil society reports that harm reduction funding is likely to be secure in the near future, as it is explicitly included within national plans. However, it is not clear whether this investment will be increased, remain at current levels, or whether it may be harder for harm reduction programmes to access funds in the future. As in some other countries within the EU, funding derived from gambling profits has been allocated towards drug related programmes in the past. The National Bureau for Drug Prevention manages these funds, which have supported harm reduction programmes previously. Ultimately, however, it is the political support for harm reduction approaches at government level that will determine the future of harm reduction investment in Poland.

Case study country
Hungary - A snapshot of harm reduction funding

Research undertaken by Peter Sarosi and Robert Csák

Harm reduction coverage

People who inject drugs	2,910 - 3,577
NSP	Low coverage – 30 sites with NSP distribution equating to 28 syringes per person injecting drugs in 2014
OST	Low coverage – up to 20% of the opiate using population receive OST
DCR	Not available
Prison harm reduction	No prison-based harm reduction programmes are available
Take home naloxone	No take-home naloxone programmes

Transparency of spending data

There is no mechanism currently tracking harm reduction investment in Hungary. As in many other countries, it is challenging to isolate this from other drug and health service expenditure. For this project, data was gathered directly from service providers to establish a picture of national spending. This was time-intensive and had its limitations as not all service providers could share their spending records. Some were reluctant to be fully transparent about grants they received to supplement their funding from the government for fear of jeopardising their access to funds in the future. While this research provided some insight into the national investment in harm reduction, these limitations render accurate routine tracking of harm reduction extremely challenging at the level of individual NGOs or institutions.[13]

Government investment in harm reduction

The vast majority of funding for harm reduction comes from the central national budget of the Government, with a small proportion from local, private and international sources. There are two major government sources of funding for NGOs providing harm reduction services. The first is the basic operational grant which provides a fixed annual amount of about €24,000. NGOs can apply for one grant per year regardless of their reach or scope of services they provide. This is not sufficient to cover operational costs for the larger service providers, so they are required to supplement this funding with other money. Some do so through other government health and social care grants and some through European Union structural funds aimed at improving employment, 'recovery' or other interventions.[13]

The second source of government funding is the KAB-FF tenders, under the heading of "Supporting the recovery of addicts", which are distributed by the Ministry of Human Resources. This funding covers a wide range of services for people who currently and previously used drugs. Harm reduction service providers are eligible to apply under two funding categories; low threshold services and OST. In 2012-2014, of 58 organisations receiving funds, 29 included NSP among their services.[13]

The following estimates of government investment in harm reduction have been calculated through Harm Reduction Works! Research. However, given the multiple limitations in gathering this information they must be viewed as indicative best estimates rather than as a wholly accurate representation of national spending. In 2014, it is estimated that €456,093 was spent on the provision of needle and syringe programmes, via 19 service out of 30 service providers in the country.[i] Approximately 92.4% of this spending was covered by government funds.[13] In 2014, the MAC AIDS Foundation gave a small grant of around €16,000 to the NGO Blue Point, the organisation that operated the largest NSP in 2014.[13]

OST provision is primarily funded through the National Health Insurance Fund of Hungary. In 2014, it is estimated that €774,930 was spent on OST provision, wholly by government funds.[j]

i These 19 service providers were responsible for 96% of the total NSP provision in Hungary in 2014.

j This was calculated by estimating the cost of provision of methadone maintenance treatment at 330,000 HUF per client and the cost of buprenorphine-naloxone treatment at 370,000 HUF per client. This included the cost of medication and the working hours of public health professionals. This method was determined the most accurate by the national researchers after approaching each service provider for spending data yielded only partial information.

In addition, the largest safer nightlife service provider INDIT has an annual budget of around €25,800 per year, which includes state funding and a small grant for activities at an annual festival from the festival organisers.

There is some evidence to suggest that people who use drugs also invest in their own harm reduction. Researchers report that there is a black market for sterile injecting equipment with syringes sold for between €0.32-1.61 depending on how difficult they are to access in the area. While some OST providers do prescribe buprenorphine-naloxone (Suboxone) for free, several OST clients have to purchase this in pharmacies because it is not fully covered by health insurance. Researchers estimate that this is, however, a small proportion of those receiving the treatment in the country.[13]

Sustainability of harm reduction funding

Harm reduction funding is considered to be under threat in Hungary by national civil society groups. Following austerity measures and a change of government in 2010, the funding situation for harm reduction in Hungary declined. A new drug strategy was adopted which deprioritised harm reduction and included a goal for Hungary to become drug-free by 2020. This had an immediate impact on funding for harm reduction. Labelled budget lines for harm reduction were removed from the annual requests for tenders from the Ministry of Social Affairs and Labour and the total available amount was reduced from €2.6 million to €1.3 million. This caused harm reduction NGOs to compete with recovery organizations for a reduced amount of funding. NGOs were also only permitted to receive one grant each, further limiting the accessibility of funds. Civil society made efforts to advocate for an improved funding system which would allow funding to be proportionate to programme size, but these funding restrictions eventually led to the closure of the two largest NSP providers in 2014. Overall, civil society reports that harm reduction funding is increasingly insecure in Hungary, with no clarity on which NGOs can expect funding in the long-term and most left uncertain about the possibility of grant extensions until they are due.

Among people attending NSP, the injecting of new psychoactive substances (NPS) tripled in Hungary between 2011 and 2015, when it was found that 80% of all clients were injecting NPS. Within this group, it was also found that hepatitis C prevalence had doubled and that sharing of syringes and other injecting equipment was significantly higher than among other people injecting drugs.[28] Researchers and civil society warn that these factors are contributing to increases in blood-borne infections among people who inject drugs and that public health emergencies are likely.[29]

While there is an innovative initiative to fund drug treatment programmes through a gambling industry tax, the funds will not be directed towards harm reduction initiatives.[13]

This research found that in 2014, the total estimated national spending on harm reduction[k] in Hungary amounted to just €1.26 million. By contrast, researchers estimated expenditure on punitive drug law enforcement in the same year to be approximately €2 billion, almost 2,000 times the amount spent on harm reduction.[13][l] If a tiny proportion of this expenditure was redirected to harm reduction this would transform harm reduction programmes in the country and save countless lives.

k Here encompassing NSP, OST and safer nightlife programmes.
l This was estimated by calculating the total spend on police, justice system, incarceration divided by the percent of drug related crimes compared to the number of total registered crimes in Hungary.

Case study country
Greece - A snapshot of harm reduction funding
Research undertaken by Fivos Papamalis

Harm reduction coverage

People who inject drugs	5,120 (4,209 - 6,303)
NSP	Low coverage – 16 sites delivered the equivalent of 70 syringes per person injecting drugs in 2014
OST	High coverage – 8,426 people were receiving OST in 2014
DCR	Not available
Prison harm reduction	OST is available in two prisons and in 2014, only 80 people were receiving OST within prison. No NSP available
Take home naloxone	No take-home naloxone programmes

Transparency of spending data

While the Greek Reitox National Focal Point for the EMCDDA has gathered some information on drug policy expenditure, this has not been routinely collected and the data have not been disaggregated in a manner that allows harm reduction spending to be easily identified.

With no central repository of this information, establishing national harm reduction investment requires analysis of the annual spending records of each harm reduction service provider in Greece. This is the approach that was taken within this project and several limitations were apparent. Aside from being time-consuming, it was also challenging to gather a full picture of national spending as some service providers were not willing or able to be fully transparent about their spending. Harm reduction interventions are often delivered alongside other services and their specific costs not labelled within spending records. There is no standardised method of recording programme expenditure, which makes it challenging to compare spending across providers and come up with meaningful national estimates of harm reduction spending. The information gathered therefore represents best estimates of spending and must be considered with caution.

Government investment in harm reduction

The National Reitox Focal Point to the EMCDDA estimated NSP expenditure in 2014 to have amounted to €2,529,901. This included expenditure of the main harm reduction service providers that included NSP within their activities.[30] The Greek agency against drugs "OKANA" is the main NSP provider in Greece, responsible for approximately 78% of NSP service provision in the country. In 2014, OKANA spent an estimated €1,476,000 on NSP provision.[30, 31] This investment covered the operation of low threshold harm reduction programmes and included NSP, condom distribution, medical services and day centres operating mainly in Athens and Thessaloniki. Approximately 80% of this investment was covered by the State Budget with funding from the Ministry of Health and the remaining 20% from contributions of the European National Strategic Reference Framework (ENSRF) programmes and Greek private donations.[30]

In 2014, an estimated €23,259,784 was invested in OST provision in Greece.[30] OKANA is the exclusive provider of OST in the country and this service is wholly funded by national government investment. In 2015, national investment in OST reduced to €18,931,361 which covered OST delivery at 54 sites.[31] National OST investment has been decreasing since its peak in 2012, when €38,416,939 was spent on OST delivery. This latest decrease equates to spending being halved between 2012 and 2015. It is reported that this has affected the quality of services, led to significant understaffing and reduced salaries. An additional €119,812 went towards two OST sites within prisons.[31]

Although there are no official estimates of the out-of-pocket harm reduction spending of people who use drugs, there is evidence to suggest that many people do pay for their own harm reduction. Methadone and buprenorphine are sold on the black market, with prices ranging from €20-50 for 60mg methadone and €6-15 for 8mg suboxone/subotex. While pharmacies can sell needles and syringes, many pharmacists in Athens will not sell these to people they suspect of injecting drug use. As a result, people buy injecting equipment from the streets, sometimes at five times the pharmacy sale price (€0.20 per syringe from pharmacies versus €1 street price).

Sustainability of harm reduction funding

Following the rapid increase in HIV among people who inject drugs in 2011, the government invested in the increase of harm reduction in Greece, by establishing a coordinated harm reduction response which saw the reduction in HIV infection among people who inject drugs in the following years. However, there is concern that the gains made could now be lost, as public austerity measures have negatively affected harm reduction funding to the point where this has begun to significantly reduce. The contribution of European and international donor funds has now also reduced and cannot be considered a sustainable source of funding for harm reduction in Greece. As recommended by the EMCDDA, the Greek authorities should consider provisionally excluding harm reduction programmes from public spending cuts to protect people who inject drugs and to avoid another public health emergency.

In recent years, there has been an increasing emphasis on punitive drug policy implementation in Greece, including increasing drug-related arrests, forced medical examinations and preventing access to harm reduction services.[30] It is recommended that a cost-benefit analysis of drug policy spending is conducted to ensure that government spending on punitive drug law enforcement does not further undermine the potential for harm reduction in Greece. This will also facilitate the Greek authorities to implement evidence based resource relocation of public drug expenditure and invest in effective and cost-effective interventions.

Case study country
Lithuania - A snapshot of harm reduction funding

Research undertaken by Jurga Poskeviciute

Harm reduction coverage

People who inject drugs	6,056
NSP	Low coverage. 9 sites regularly and 2 sites occasionally provide NSP
OST	Low coverage. 19 sites with clients receiving buprenorphine or methadone
DCR	Not available
Prison harm reduction	Not available, although OST can be continued in detention centres under the Ministry of Internal Affairs for those already receiving it
Take home naloxone	In 2016, the Vilnius Centre for Addictive Disorders began providing naloxone to people upon release from in-patient detox programmes

Transparency of spending data

In Lithuania, no spending information related to harm reduction is collected at the national level. There is some information on budget allocations (which can differ dramatically from actual spending) available but these are within programmatic documents or institutional budgets and figures are inconsistent methodologically and difficult to compare. There is also a reluctance to share information from the National Centre for Communicative Diseases and AIDS and the Prisons Department under the Ministry of Justice, which poses challenges to establishing an accurate picture of the situation.[32]

Research carried out by the "I Can Live Coalition" in the context of a Global Fund regional grant held by the Eurasian Harm Reduction Network has already gathered detailed information on the funding situation in Lithuania. It is only for this reason that estimates on NSP and OST were readily available and simply required updating, rather than additional data gathering.

Government investment in harm reduction

NSP in Lithuania is supported by funding from the national government budget (45%), from municipal government budgets (49%) and from one international donor (American Health Foundation) (6%).[32] There are no available spending records isolating NSP investment, so for this research a calculation was made based on the average cost of NSP delivery per client, multiplied by the estimated number of regular NSP clients. When based on the average cost for client multiplied by the official estimate of regular NSP clients,[m] the estimate of spending in 2014 was about €306,190. However, the "I Can Live Coalition" found discrepancies in the official estimate of regular clients which suggested this to be somewhat inflated.[33] Therefore, to determine a more accurate representation of spending, the average cost per client was multiplied by an estimate of the number of regular clients that had been extrapolated from the estimates of 2012 and 2013, which seemed appropriate given that there had been no funding or service provision increase since this time. This produced a spending estimate for NSP in 2014 of between €150,000 and €160,000. Through Harm Reduction Works! research, financial data from nine out of eleven NSP sites in the country was gathered which suggested this estimate to be more accurate.[32]

The cost of OST provision is solely covered by national government funds, with the exception of buprenorphine, which is provided at a cost to the client. For this research, it was estimated that government spending in 2014 equated to €333,602. This calculation is based on the average cost of OST provision per client multiplied by the number of people receiving OST on December 31st, 2014, including those in detention centres. As buprenorphine is provided at a cost to a client this is not reflected in the estimate. According to studies carried out by the "I Can Live Coalition", at least a four-fold increase in funding is needed in order to reach the recommended coverage of 40% of the estimated people who inject drugs in Lithuania with an optimal package of OST services.[33]

m Attending services at least once a month in the last 12 months.

No international funding sources had existed for OST in Lithuania since the UNODC project "HIV/AIDS prevention and care among injecting drug users and in prison setting in Estonia, Latvia and Lithuania" finished in 2011. With the end of this project, the number of OST patients dropped in 2011 and again in 2013.[32]

Until 2016, funding for OST has been allocated in two ways – direct allocations to drug dependence treatment clinics through the National Program for Treatment of Dependencies and through partial allocations of the National Health Insurance Fund. Starting in 2016, all treatment services are reimbursed by the Fund to clinics based on the actual number of services provided. Usually budget ceilings exist in the annual budget of the National Health Insurance Fund, but overspending can be covered periodically from reserve funds.[32]

Funding allocations for NSP from the national government budget are guided by the National Drug Control and Prevention Program that is developed every few years, in conjunction with an Inter-institutional Action Plan, including annual allocations for specific actions. These allocations are reviewed by each implementing institution each year, so the Action Plan can be modified annually. This allocation is distributed through an annual grant competition for a maximum amount of €6,000 each to non-budgetary funded organisations (usually 2-3 NGOs will receive funds this way, but there are only one or two more that would be eligible). The money remaining from the grant competition is then used to buy NSP supplies and distribute to all sites based on the need that the sites identify.

Municipalities that fund NSP also allocate funding annually through various municipal programmes such as health or social affairs. This is a completely separate process to national government funding allocations for NSP. Of all the municipalities, one provides four-year budget allocations for NSP, providing more security for the longer term provision of services.[32]

While there are no available estimates of government expenditure on drug law enforcement and punitive drug policy measures, this investment is given higher priority over health and harm reduction measures. Recent changes in the Administrative Code will leave sanctions for possession of small amounts of illicit substances purely a matter of Criminal Code, which the "I Can Live Coalition" warns will mean more criminalisation for drug possession, when many countries are moving away from this approach.[32]

Sustainability of harm reduction funding

It is likely that the government has the capacity and political will to sustain harm reduction funding at current levels for the next five years. There is already a significant funding gap for harm reduction in Lithuania, however, so increased funding is necessary. The "I Can Live Coalition" estimate that bringing coverage levels up to UN standards would require a six-fold increase in funding for NSP and a four-fold increase in funding for OST. Currently, NSP sites are regularly subject to supply shortages and have periods of funding gaps which mean they run the risk of closure. The services they provide are not deemed extensive enough (for example they do not offer hepatitis C testing, overdose prevention or linkage to HIV services and there is limited outreach) and the hours that they currently open are very limited. In addition, there is a need for services tailored towards women and people who inject amphetamines. There are not enough OST sites across the country, the quality of service provision outside Vilnius requires improvement and OST programmes should be initiated within prisons under the Ministry of Justice.[32]

Harm reduction funding in Lithuania has been decreasing since 2011, following the end of a UNODC grant. The government did not intervene to support the programmes that UNODC had been funding and the number of both OST and NSP clients has been steadily dropping each year, while at least two NSP sites have stopped providing services altogether. Further research is necessary to determine the impact of this on the health of people who inject drugs in Lithuania. There are plans by the Ministry of Health for investments into new OST and NSP sites from EU structural funds (which cover infrastructure costs only) that could potentially be used to expand the current coverage and scope of services. There is now also a plan for OST in prisons to become available under the Ministry of Justice, following much civil society advocacy on the issue to show that there were no legal or other barriers to offering this service. This is particularly urgent given a recent significant rise in new HIV cases within prisons in 2016.[32]

To increase the sustainability of funding for harm reduction in Lithuania, there would need to be clear institutional leadership, support and oversight for harm reduction service provision, which is currently lacking. The responsibility for ensuring NSP is provided in Lithuania falls to a government agency that is not supportive of harm reduction approaches. Advocacy for harm reduction in Lithuania is strong and the "I Can Live Coalition" is actively involved in advocating for harm reduction investment. The recent regional Global Fund grant held by EHRN provided an opportunity to explore the funding situation in detail and to build some capacity for funding advocacy. There is a distinct need for continued capacity building in this area to support advocacy efforts and to ensure that existing services are protected and investment levels increase, or at least are not subject to reductions.[32]

Case study country
Italy - A snapshot of harm reduction funding
Research undertaken by Susanna Ronconi

Harm reduction coverage

People who inject drugs	326,000
NSP	Low coverage but huge regional variation – 72 sites reaching about 15% of opioid users in Italy
OST	High coverage, 620 OST sites provided OST to 70,699 people in 2014
DCR	Not available
Prison harm reduction	OST available in all prisons. No NSP in prisons
Take home naloxone	National take-home naloxone programme

Transparency of spending data

There is a need for monitoring of harm reduction implementation and spending at national level. However, without explicit and clear political support and no inclusion in national drug policy guidelines, there is no requirement to include harm reduction within national monitoring and evaluation systems. As a result, expenditure is often hidden in general drug service spending records and not disaggregated in a way conducive to identifying harm reduction spending. Only eight of twenty Italian regions have disaggregated spending accounts, which allow some insight into harm reduction spending. However, data are not available for all years, and are not disaggregated in enough detail to isolate NSP-related expenditure. OST spending is embedded in the overall spending records of the Public Drug Addiction Units within which OST centres are held. The only cost that can be isolated is that relating to the medication itself, not its provision.[7]

Differences in harm reduction data gathering between regions in Italy pose a challenge to effective national monitoring. There are political and methodological steps to be taken to ensure the development of national harm reduction guidelines and a new data gathering system which explicitly includes harm reduction services.[7]

Government investment in harm reduction

The majority of harm reduction investment in Italy (90-95%) comes from public budgets at the regional level which are locally held by local health agencies known as ASL. In very few cases, harm reduction funding comes in part from municipalities (e.g. Venice and Rome) or national private donors such as banks or private foundations. Funds from the Justice and Social Affairs departments of the European Commission contribute to some research, training or experimental interventions related to harm reduction, but no funds go directly to service provision.

In 2014, an estimated € 18,892,440 was spent on drop-in harm reduction services, including NSP in Italy.[n] There was a clear drop in harm reduction funding and service provision between 2010 and 2014, when NSP sites decreased from 106 to 72 and NSP coverage fell from 24% to 15%.[o] The few regions where harm reduction is more established may have maintained stability in their harm reduction budgets during this period, but at the national level spending decreased from approximately €22,207,000 to €18,892,440.[p]

In 2014, NSP spending varied dramatically between regions, with €3,246,140 spent in Regione Lazio, €1,979,200 spent in Regione Emilia Romagna and just €540,000 spent in Regione Toscana. Trends in expenditure also differed between regions, with Regione Emilia Romagna having stable investment from 2010 to 2014, Regione Lazio reducing its harm reduction budget by about 27% and Regione Toscana increasing it by

n This estimate includes the cost of all services provided by the drop-in centres and via outreach, encompassing NSP, take-home naloxone, HIV/HCV testing, social aid, counselling, medical visits and first aid.
o Calculated for this project using a denominator of the number of people using opioids problematically, in Ronconi S (2016) Harm reduction works! Research.
p The national spending estimate is based on average yearly spending of 5 NSPs (2 in regione Lazio, 1 in Veneto, 1 Emilia Romagna, 1 Umbria) multiplied by the number of NSPs in Italy, in Ronconi S (2016) Harm reduction works! Research.

8%.[q] These variations may reflect differences in programme need across the regions, but also the political support that regional decision-makers had for harm reduction at a time when national budgets were being cut in several areas due to austerity. As NSP and wider harm reduction services are not yet included among the list of essential services (Livelli Essenziali di Assistenza, or LEA) that all regions must provide to citizens, regional decision-makers can determine the extent to which these services are made available.

In 2014, €30,018,724 was spent on pharmaceutical costs related to OST (including methadone, buprenorphine, naloxone and suboxone).[r] Isolating spending related to OST delivery across the country is very challenging, as this service is integrated into the public health system and spending that particularly relates to OST delivery, such as staffing and infrastructural costs, are not disaggregated. While this project could not gather data for the whole country, it was possible to gain an insight into OST expenditure and trends over time in selected regions.[s] When delivery costs are considered there is some evidence of a reduction in investment since 2010: from €147,785,828 to €106,896,888 in 2014. This is due partly to cuts to public health funds and partly to a 32% decrease in the number of OST clients. Overall, OST remains relatively adequately financed, despite the wider public health cuts seen in Italy in recent years. In 2014, coverage was estimated to be 57% compared to 48% in 2010.[t] OST, unlike NSP and other harm reduction services, is included among the LEA that all regions must provide to citizens.

There is no estimate of out-of-pocket harm reduction spending, but this is likely to be substantial in one-third of the country, where no NSP services exist.

Through their taxes, every Italian citizen contributes €0.31 per year towards NSP delivery (2014). They also contribute €18.69 per year to support drug law enforcement (covering costs of policing, trials and imprisonment).[34] Reaching 100% NSP coverage (rather than the current 15%), would cost each tax payer €2.07 per year. This cost could be covered by shifting just €1.76 from their contribution to drug law enforcement and repression, over to health and harm reduction.[u]

At the national level, the government allocates an amount to the National Health Fund each year, which includes funding for the drug and drug treatment sector. These allocations are discussed at the regional level and distributed between different sectors according to regional health plans. The drug and drug treatment sector is not allocated a fixed percentage. Austerity has led to continual cuts to regional health budgets, and even those programmes that are included on LEAs may receive insufficient funds as a result.[v] In 2017, there are moves to include harm reduction (including NSP) within the LEA which will improve the funding situation. In terms of harm reduction funding advocacy, it is possible to advocate for harm reduction allocations at all the different levels of decision making, but this is more feasible and effective at the regional level.[7]

q Prevention and Treatment Department - Regione Toscana; Drug Addiction Department - Regione Emilia Romagna; Drug Addiction Department - Regione Lazio, in Ronconi S (2016) Harm reduction works! Research.
r Health Institute - Pharmacoepidemiology Department; OsMed annual Reports, in Ronconi S (2016) Harm reduction works! Research.
s The national spending estimate is based on average yearly spending of 5 OST sites (3 in regione Piemonte, 2 Emilia Romagna) multiplied by the number of OST in Italy, in Ronconi S (2016) Harm reduction works! Research.
t This was calculated using the numerator of the number of people enrolled in OST programmes and the denominator of the estimated number of people using opioids sourced from DPA Annual Reports available at http://www.politicheantidroga.gov.it/attivita/pubblicazioni/relazioni-al-parlamento.aspx
u Calculated by Susanna Ronconi for this project.
v Livelli Essenziali di Assistenza are the standard, totally or partially free services guaranteed to all Italian citizens by the National Health System.

Sustainability of harm reduction funding

Until 2014, Italian drug laws and policies were particularly prohibitionist and did not support harm reduction. The National Drug Agency focused on both repression and a rigid disease paradigm, alongside a demand reduction approach favouring abstinence. While some Italian regions have a long history of implementing harm reduction since the mid-1990s, two-thirds of the regions do not have harm reduction guidelines and one-third do not run harm reduction services at all. In 2014, the most repressive articles of the drug law were abrogated by the Constitutional Court, under pressure from civil society. At the same time, staff changes at the new National Drug Agency saw the beginning of a change in Italy's approach to drugs. One of the first signs of innovation - thanks to coordinated advocacy by civil society organizations, professionals and drug user activists – has been the proposal to include harm reduction interventions in the LEA. In late 2016, harm reduction was approved by the Ministers Council as part of the new LEA, which in effect, requires all regions to implement harm reduction services.[w] As over 90% of harm reduction funds are derived from public sources, this will make a significant difference to the sustainability of Italy's harm reduction response. The next step is for the Conferenza delle Regioni to develop minimum standards for harm reduction, which will be an important moment for national harm reduction advocacy.[7]

Currently, a large proportion of Italy's NSPs do not have the security of stable funding. While some are established services, others remain projects which are time-limited with the potential to be renewed or have funding discontinued. In 2014, one-third (29%) of all harm reduction services (including, but not limited to, NSP) were considered stable services, 22% had a two-year term, 38% had a 1-2 year term and 11% had less than 11 months of secured funding.[x] The projects with the least stability are safer nightlife interventions aimed at young people.

> ***'In Italy, current drug policy is not investing for the future'.*** Susanna Ronconi, Harm Reduction Works! researcher.

The majority of harm reduction service providers in Italy are also active harm reduction and drug policy reform advocates. There are a small number of networks of people who use drugs but they are rarely included in policy-making processes. There is a need for renewed and improved opportunities for participation of all relevant stakeholders in national and local decision-making. There is a need for further evidence of harm reduction's success in reducing HIV and hepatitis C infection, as well as preventing overdose in Italy through research, monitoring and evaluation. There is also a need for cost-effectiveness and cost-benefit analyses of harm reduction and wider drug policy implementation to inform strategic budget allocations at national level.

> ***'At the municipal level, the harm reduction discourse must be developed in order for cities to be protagonists of harm reduction as a social and community approach, and not only as a health policy.'*** Susanna Ronconi, Harm Reduction Works! researcher

w See DPCM LEA, at http://www.quotidianosanita.it/allegati/allegato5864831.pdf
x DPA Annual Report 2015 available at http://www.politicheantidroga.gov.it/attivita/pubblicazioni/relazioni-al-parlamento.aspx

Sweden - A snapshot of harm reduction funding

Harm reduction coverage

People who inject drugs	8,021
NSP	Low coverage – 10 sites serving only one-quarter of people who inject drugs
OST	High coverage, 159 sites with a reported 3,502 people receiving OST in 2014
DCR	No DCRs
Prison harm reduction	OST available to those who had been receiving it prior to imprisonment. No NSP in prisons
Take home naloxone	Not available, but currently civil society action on this issue

Transparency of spending data

The team assembling the data for this report was not able to identify sources of financial data broken down by programme within the scope of this project. Dedicated research and analysis would be necessary to gain insight into national harm reduction spending.[35]

Government investment in harm reduction

Harm reduction investment in Sweden is wholly government funded through national health and social budgets. No publicly available estimate of spending on either NSP or OST programmes was identified for the country. The only published data found related to the amount budgeted for HIV prevention in 2014, which amounted to approximately €15.3 million,[36] but it is not clear what proportion of this went towards preventing HIV among people who inject drugs. Harm reduction investment is likely to have increased between 2010 and 2014 to support the establishment of additional NSP and OST sites, although there is no spending data available to confirm this.[35]

Accessing NSP is free in Sweden but coverage is low. In areas where NSP is not available, people who inject drugs are sometimes able to access injecting equipment from local drug users' unions. However, pharmacies are not permitted to sell needles and syringes to people suspected of using them to inject illicit drugs. In addition, it is illegal for individuals to import needles and syringes into Sweden.[37] OST provision is free for people who receive social security support, but others are required to pay a maximum fee of approximately €315 per year for OST.[35]

Health care is decentralised to the regional level in Sweden which is where most funding allocations for harm reduction programmes are determined. While it is decided at the national level which interventions are permitted within the country, to some extent, harm reduction investment is related to the level of political support among decision makers in regional government.[35]

Sustainability of harm reduction funding

Limited political commitment is the main barrier to sustainable harm reduction funding in Sweden. While the current government has embraced components of harm reduction at the national level more than previous governments, there is a concern among harm reduction advocates that elections in 2018 could threaten the progress made thus far. Laws and policies also pose significant barriers to harm reduction implementation. For example, community distribution of naloxone is not currently permitted in Sweden as its use is limited to emergency services personnel.[35]

There is a need for investment and capacity strengthening in harm reduction advocacy at the national and county level in Sweden. This need also extends to calling for necessary changes to laws and policies and ensuring that investments and the current policy environment is maximised to deliver quality services.

The Swedish Drug Users Union has carried out important harm reduction advocacy alongside academics, but this work is severely underfunded. There is currently no national platform for harm reduction actors to advocate for increased investment or policy change, nor to hold the government accountable to national and international commitments. Importantly, a harm reduction network is starting to form organically and includes key actors from the drug user community, academia, policy professionals and service providers.[35]

Case study country
Czech Republic - A snapshot of harm reduction funding
Research undertaken by Jiri Richter

Harm reduction coverage

People who inject drugs	45,600
NSP	Medium coverage – 6.6 million syringes distributed by 105 sites in 2014. Also available to purchase from pharmacies
OST	Low coverage – 4,000 clients receiving buprenorphine or methadone in 2014
DCR	Not available
Prison harm reduction	No NSP. 50 prisoners receiving OST in 2014
Take home naloxone	Not available

Transparency of spending data

In the Czech Republic, there are mechanisms in place that serve to track some aspects of harm reduction expenditure. Through the National Focal Point to the EMCDDA and financial reporting of the Government Council for Drug Policy Coordination (GCDPC), the spending related to NSP is annually tracked. Spending related to OST is more challenging to establish as this is not isolated within financial reporting and OST is delivered in different settings which report their financial expenditure in different ways. Further study was recommended and any additional information could bring new insight and be used as a basis for better structured, more stable funding for harm reduction.[38]

Government investment in harm reduction

Drug policy implementation, of which harm reduction is a part, is accounted for in budgets allocated to the Secretariat of the GCDPC, the Ministry of Education, the Ministry of Defence, the Ministry of Health, the Ministry of Labour and Social Affairs and the Ministry of Justice. Projects involving drug services also receive financial support from the European Structural Funds. Funding for harm reduction initiatives is a significant part of drug policy funding overall, but it is not planned, budgeted or distributed separately. This makes tracking harm reduction-specific funding allocations or spending extremely challenging. The exception to this is spending for NSP, which is estimated by the National Focal Point for the EMCDDA and by the GCDPC. OST service spending, however, is reported within a wider package of outpatient services so therefore cannot be extracted.

In 2014, harm reduction was funded mainly from national budgets (GCDPC, Ministry of Health & Ministry of Labour and Social Affairs) and regional and municipal budgets. Some NSP services were also covered partially by public health insurance, which was also the main source of funding for OST services. A very small proportion of both NSP and OST funding was from international donors in 2014. It is estimated that a total of €13,415,900 was spent on harm reduction in 2014, covering OST and NSP services.[y]

There are two available estimates of the national investment in NSP service provision. The first comes from financial reports of the GCDPC which state that €6,497,000 was spent on the NSP in 2014. The second is the annual report of the Reitox National Focal Point to the EMCDDA which states that for 2014, NSP spending from public budgets amounted to €7,062,900. It seems more appropriate to use the latter estimate because the GCDPC financial reports do not include all existing spending. This equates to roughly 58% from national government funds and the majority of the rest from regions and municipalities, with a very small contribution from international donor funds.[38]

As mentioned, OST provision spending is harder to estimate, as this is embedded within wider outpatient service budgets. OST programmes are provided within a range of settings including state-run and NGO services, both with and without contracts with public health insurance companies, separate OST programmes or (in most cases) within drug treatment or psychiatry outpatients' services. Financial records from services

y This includes €7,062,900 for NSP and €6,353,000 for OST, in Richter J, SANANIM (2016) Harm Reduction Works! Research.

(held centrally by GCDPC) or from public health insurance do not disaggregate OST provision costs from those relating to other services offered within the same facility.

Analysis of financial reports from the GCDPC suggests that OST provision expenditure reached €471,590 in 2014, of which €42,650 was provided from government funds. This estimate does not include state facilities, which account for the majority of OST provision in the country. A crude calculation using the average cost of annual suboxone provision and multiplying this by the number of clients in the country produces an estimate of €6,353,000, which would have been wholly covered by public health insurance in 2014.[38] [z]

Some drug services receive financial support through European Structural Funds (ESF). In the period 2010-2014, for example, a total of €3,584,000 was made available for programmes intended to facilitate social inclusion and employment opportunities for people who use drugs as part of three grant calls announced by the Ministry of Labour and Social Affairs. It should be noted that all projects funded by ESF must be co-financed to the value of 15% by the government. It is estimated that between 2009 and 2013, contributions from ESF in the total funding of drug treatment services amounted to about 12%. It is not possible to determine whether the financial resources were used for harm reduction activities.

In 2014, eighty programmes distributed approximately 200,000 gelatine capsules for oral methamphetamine use as a harm reduction intervention to avoid injecting drug use.[38]

Experts estimate that between 1-1.5 million needle and syringe sets were sold through pharmacies in 2014.[38] With the average price of one set being around € 0.10, this would equate to a total of between €100,000–150,000 out-of-pocket harm reduction expenditure for people who inject drugs in the country.[38]

In addition, most OST clients are required to pay full price for their buprenorphine prescriptions, which equates to thousands of Czech crowns per month from their personal resources. This leads to clients obtaining prescriptions for a greater quantity of medicines than needed (a practice known as "doctor shopping"), to sell at higher prices on the black market as a way of financing doses for themselves.[39]

The coverage of substitution medicines by health insurance remains an issue. Full reimbursement only applies to Suboxone, but the eligibility requirements are so restrictive that very limited coverage is provided. As of August 2015, only four facilities were known to provide treatment with reimbursed medication to approximately 75 patients.[38]

Sustainability of harm reduction funding

In the Czech Republic there is a relatively long history of harm reduction implementation, supported by a large network of services and professionals including academics. The legal and policy framework provides a solid basis for harm reduction to receive continued funding in the near future. However, political will for harm reduction and national policies might be subject to change, as there is no law obligating the provision of these services.

While there has been a small increase in harm reduction funding in recent years, there remain gaps in service provision that require additional investment. There is a reported a gap of €3,676,000 which is required to cover basic operational costs of existing NGO services.[aa] Another €1,838,000 is required to increase the coverage and accessibility of OST services nationally, NSP in the regions of Prague, the North east and North Moravia and to cover the cost of drug consumption rooms in Prague.[bb]

Only a small proportion of the ESFs that the Czech Republic receives are likely to be supporting harm reduction, so this support could be utilised more fully. Many of the projects receiving ESF do not continue as the 15% state contribution is challenging to sustain.[38]

In conclusion, the harm reduction funding situation in the Czech Republic is relatively good compared to its close neighbours in Europe. However, there is room to improve the stability of funding, to increase it to cover service provision gaps and increase political support at the regional and local level to increase the sustainability of this funding for the future.

z This is a crude calculation based on one month Suboxone provision costing 3,600 CZK and provision for one year costing 43,200 multiplied by 4000 (number of estimated clients).
aa Estimated for this project by subtracting spending estimates from the funding requested for harm reduction in the country. Richter J, SANANIM (2016) Harm Reduction Works! Research.
bb Estimated for this project by subtracting spending estimates from the funding requested for harm reduction in the country. Richter J, SANANIM (2016) Harm Reduction Works! Research.

Case study country

Portugal - A snapshot of harm reduction funding

Research undertaken by Marta Pinto

Harm reduction coverage

People who inject drugs	14,426 (12,732-16,101)
NSP	Medium coverage
OST	High coverage, around 75% of 'high-risk opioid users' receiving OST
DCR	Not available
Prison harm reduction	OST available in all prisons. Pilot NSP in 4 prisons opened in 2007 but were closed after 6 months
Take home naloxone	One pilot programme in Braga

Transparency of spending data

There are barriers to obtaining a clear understanding of harm reduction funding in Portugal. Publicly available spending records are scarce, not easily interpreted and do not allow a clear understanding of funding of harm reduction interventions. In addition, information gathered through different sources can be contradictory rendering it difficult to establish a true picture of the situation. While there was willingness from SICAD (the government department responsible for drugs) to share spending information, some data are simply not available and the criteria and limits placed on harm reduction funding allocations are unclear.

'The existence of projects such as 'Harm Reduction Works!' helps to legitimise enquiries and requests for clarification on harm reduction funding. This project has already opened doors to solve many of these problems in the future since it has created the conditions to start a dialogue between civil society and government on funding.'
Marta Pinto, Harm Reduction Works! researcher, Portugal

Government investment in harm reduction

The funding for harm reduction projects, including NSP, is managed by SICAD but originally comes from Santa Casa da Misericórdia, which is a private organisation that uses a proportion of their revenue from social gambling (e.g. from 'joker' or 'Euromilhões') to fund some social projects. SICAD allocates funding to harm reduction service providers that apply for grants. Local government departments responsible for drugs also perform regular needs assessments in partnership with relevant stakeholders to inform funding allocations. According to decision makers and professionals interviewed for this project, however, the assessment process is not always as participatory as it should be, which may limit its accuracy. There are upper limits imposed for applications but the reasoning behind the limits remain unclear, for example, outreach teams can apply for only €75,000 per year and support office applications have a limit of €180,000 per year. However, applicants are only eligible for 80% of project costs, with the other 20% to be covered by the implementer. There is an ongoing civil society effort to allow projects to be fully funded by the Santa Casa de Misericórdia. Several stakeholders interviewed for this project (decision makers and harm reductions professionals) stated that financial engineering was a fundamental skill necessary to make the best out of their budgets.

In 2015, an estimated €3,330,397 from the Santa Casa de Misericórdia funded 40 harm reduction projects.[cc] There has been a scale-up of sites and investment in recent years, with 38 projects funded with €3,271,512 in 2014 and only 31 harm reduction projects operating in 2013 funded with €2,042,105.[40]

cc The kind of interventions funded as being harm reduction projects in 2014 were: outreach teams (29), low-threshold OST programmes (29), NSP (mostly implemented by outreach teams) (31), support offices (harm reduction local services) (6), safer nightlife initiatives (4), shelter centres for people who use drugs (3).

In addition, every year approximately €1,000,000 covers the cost of syringe distribution through NSP sites including pharmacies. Stakeholders note that there is a need for some improvements in the materials offered (for example, the inclusion of various diameters of needles and tourniquets in NSP packs).[41]

The cost of methadone delivery is wholly government supported. As OST provision is fully integrated into the public health system in Portugal it is not possible to easily isolate the costs involved in its delivery, however, some insights were gathered on the cost of the medication itself. Public expenditure on OST medications amounted to an estimated €4,179,571 in 2014, which included methadone, buprenorphine and buprenorphine/naloxone, but this estimate did not include medication prescribed within hospitals.[42]

There is no available estimate of out-of-pocket spending from people who use drugs on harm reduction. There may be significant spending in rural areas where NSP are less accessible, but stakeholders also mention a need for equipment not currently provided through NSP services, which people may purchase themselves.[dd]

Sustainability of harm reduction funding

Harm reduction has been somewhat protected from the impact of austerity cuts to the health, justice, social security and education sectors in Portugal. There is political support for the harm reduction approach and the provision of these services is considered essential by the current and former government. Since funding for low threshold harm reduction services comes primarily from a non-governmental source, it is simply political will that is necessary to sustain the current harm reduction funding levels. However, there is a need to make all the available funding for harm reduction accessible to ensure this is utilised fully and effectively.

The economic and financial crisis has had an impact on harm reduction workers. There have been funding delays which caused some projects to be suspended and others to rely on harm reduction workers carrying on delivering services without payment. The cost of living has increased but the available funds for harm reduction projects have not reflected this, making it more difficult to retain staff on reasonable salaries.

Researchers warn that the quality and availability of services are at risk due to the additional pressures on service providers and increased risk of staff burnout.[43]

> *'The extra effort of NGO workers in Portugal has been crucial to protecting people who use drugs from the impact of austerity'* Marta Pinto, Harm Reduction Works! researcher

Given the pressures the harm reduction sector is under, it is not surprising that most do not have the time to advocate for sustainable harm reduction funding. Harm reduction in Portugal is being 'stretched to its limits' and reaching people with services will always remain the priority, to the detriment of advocating for change.[41]

dd For example, needles of greater diameter and aluminium paper to inhale heroin and cocaine base.

Finland - A snapshot of harm reduction funding

Harm reduction coverage

People who inject drugs	15,611 (13,770–22,665)
NSP	High coverage – 4.5 million syringes distributed in 2014
OST	Low coverage – 3,000 clients receiving OST in 2014
DCR	Not available
Prison harm reduction	OST available in prisons. No NSP available
Take home naloxone	No take-home naloxone programmes available

Transparency of spending data

There are multiple organisations (public and private) that provide drug-related harm reduction. While the co-operation between institutions and organisations is strong, it is impossible to estimate the total amount spent on harm reduction within the country. There is currently no national tracking mechanism that could assist with this calculation.

Government investment in harm reduction

It is not possible to estimate the total amount of harm reduction spending in Finland. In 2014, the total sum spent on NSP was estimated to be between €2-2.5 million.[44] Around €1.7 million of this was invested in the Helsinki area, which is densely populated and where most of the people who inject drugs in Finland are situated. This investment was wholly covered by government funds.[44]

Similarly, OST provision is covered wholly by government funds, but there is no data available on the extent of this investment.[44]

Needles and syringes can be purchased without medical prescription at most pharmacies in Finland, and pharmacies play a key role in needle and syringe provision in areas where there are no standalone NSP services. The latest Finnish estimate of the amount of needles and syringes sold by pharmacies is over a decade old, but at that time, around 500,000 needles and syringes were sold annually.[44] A needle and syringe set is sold for an average of about €2.[44]

Sustainability of harm reduction funding

Civil society reports that the government is likely to remain supportive of harm reduction to current levels in coming years. They state that drug policy is not becoming more liberal and that law enforcement remains a very prominent feature. They lament that an increase in funding would likely only emerge in response to an increased public health threat, such as a rise in HIV infections among people who inject drugs.[44]

> *'Minimizing harm combined with punitive prohibition policy forms a two-pronged paradigm for Finland's drug policy.'* Anne Arponen, A-Clinic Foundation, 2016

Access to long-term sustainable funding for harm reduction programmes in Finland remains challenging. Additionally since 2012, funding for HIV prevention in Finland has decreased to the extent that there are now reported to be insufficient funds available. The impact of this has been more pronounced for programmes focusing on men who have sex with men and sex workers, than those for people who inject drugs. NSP funding in particular has decreased in recent years and the need for services has remained unchanged.[44]

There has been an increasing reliance on competitive tendering for service provision in harm reduction and the wider HIV sector. This pushes services to provide the same service with reduced budgets, which is reported to be affecting the quality of services being delivered. Long-term providers of harm reduction services are losing bids to new suppliers in some areas.

The services are intended to remain as they were, but changes in personnel and location threaten to weaken the trust built up between clients and personnel over long periods of service provision.

In response to this, the National Institute for Health and Welfare will produce guidelines for low threshold service centres which will include recommendations on quality, consistency and continuity of low threshold harm reduction services. The Institute will closely monitor changes of service providers and any effects on the quality and continuity of services.[44]

Case study country
Estonia - A snapshot of harm reduction funding
Research undertaken by Jaan Väärt

Harm reduction coverage

People who inject drugs	5,362 (3,906 - 9,837)
NSP	High coverage - 36 sites reached approximately 6,305 people in 2014
OST	Low coverage - 8 sites with 919 clients in 2014 receiving methadone
DCR	Not available
Prison harm reduction	OST is available. Naloxone distribution available in 3 or 4 prisons. No NSP
Take home naloxone	733 take-home naloxone kits distributed in 2014

Transparency of spending data

Within this research it was possible to gather spending estimates for NSP and OST in 2014 relatively easily due to government sources having access to this information and their willingness to share data. However, this information was not publicly available and had to be requested, and no detailed breakdown of spend was shared. As this information is collected at the national level, it would be of use to create an open access database on national harm reduction spending within a pre-existing programme, 'Statistics Estonia'.[45]

Government investment in harm reduction

An estimated €2,789,236 covered the full spectrum of harm reduction services available in Estonia in 2014.[46] ee This funding came in full from the budget of the Ministry of Social Affairs. It is estimated that at least €1,160,750 of this was spent on NSP in 2014.[47] This does not include the spending of local municipalities of Tallinn, Tapa, Kohtla-Järve, Paide, Narva and Maardu, from which it was not possible to collect data during this research.[45]

Approximately €1,040,968 of this funding went towards OST provision in 2014,[47] with €17,153 estimated to have been spent on overdose prevention and naloxone distribution.[48] The benefit of this investment was quickly evident. The number of reported overdoses steadily decreased following the implementation of the take-home naloxone programme, from 170 overdose deaths in 2012 (before the THN programme started), to 84 overdose deaths in 2015.[47]

Under the National Health Plan 2009 – 2020 in Estonia, there are shorter term implementation plans with attached budgets which include harm reduction allocations. The budget is held by the Ministry of Social Affairs, but it is the National Institute of Health Development (NIHD) that is responsible for the distribution of these funds among service providers. The NIHD draws up contracts directly with service providers and local municipalities who provide the harm reduction services, or in some cases there are tripartite agreements between the NIHD, the local municipality and the service provider.[45]

Sustainability of harm reduction funding

Harm reduction funding in Estonia is considered to be sustainable in the near future assuming there are no major shifts in the Estonian political landscape. Following the retreat of the Global Fund in 2007, the government of Estonia began fully financing the national harm reduction programme. The government has now been consistently investing in harm reduction approaches for over a decade and even maintained this investment following the economic crisis in 2008. It is encouraging that harm reduction continues to be emphasised in national health and drug strategies, plans and policies.[46, 49]

There are, however, some gaps in current service provision where an increase in investment would be valuable. The NIHD highlighted some immediate gaps to be addressed in current harm reduction provision in Estonia. These include the integration of harm reduction, health and social care services for people who inject drugs; linking the services with the prison and detention system; ensuring an appropriate range

ee This included funding for NSP, overdose prevention, STI diagnostics and treatment services for people who inject drugs, OST, sexual behaviour counselling for youth with health insurance, STI diagnostics and treatment services for women involved in sex-work, provision of infant nutrition for HIV-positive mothers, voluntary counselling and testing service, case-management for people living with HIV, specialist training and services within prisons.

of easily accessible services and improving the geographical coverage of services.[50] Service providers interviewed for this project stated that there was a need for regular needle and syringe programmes to be provided in the areas of Paldiski, Pärnu, Tartu and Jõgeva and the need for OST provision in Maardu City. They also noted that sterile water is not currently available for distribution.[45] In addition, hepatitis C treatment is not currently guaranteed for people who do not hold health insurance.[45] The NIDH also raised the lack of access to sterile injecting equipment in prisons and the need to strengthen data collection. Furthermore, the salary level of people working in the harm reduction sector is not motivating. A harm reduction worker at NGO Convictus, for example, receives a salary equal to 60%-70% of the national average wage in Estonia.[45]

In addition to increased funding, solidifying the legal status of harm reduction by defining and including it in legislation was highlighted as a valuable step that could be taken in Estonia.[45] Harm reduction currently exists 'in a no-man's land' between medical and social services. Legislative clarity would provide a more solid basis for the provision of the service and perhaps be a step towards changing legislation to allow NGOs to carry out HIV rapid testing and to provide OST.[45]

There is not currently an active harm reduction advocacy movement in Estonia to protect the interests of people who use drugs and call for improved harm reduction investment from the government. In late 2016, the first Estonian association of people who use psychotropic substances was officially registered as an NGO.

> *'Relatively good state funding of harm reduction has led to a situation in which NGOs and other service providers have become contractors whose work is defined by the government rather than the needs of people who use drugs. Fortunately, in general those two have so far overlapped.'* Jaan Väärt, Harm Reduction Works! researcher

UK - A snapshot of harm reduction funding

Harm reduction coverage

People who inject drugs	122,894 (117,370-131,869)
NSP	High coverage
OST	High coverage, including limited prescription of heroin-assisted treatment
DCR	No DCRs yet, but a planned supervised injecting facility in Scotland
Prison harm reduction	OST available in all prisons. No NSP in prisons
Take home naloxone	National take-home naloxone programme in Scotland

Transparency of spending data

Spending on harm reduction programmes is not centrally tracked so there is no repository of information on what is being implemented or spent across the UK. In order to gain insight into harm reduction expenditure in the UK, spending records would have to be accessed at the local level from commissioning groups and then be aggregated. Civil society respondents recognised this as a problem and emphasised the need to track this investment and the implications of recent funding changes. They highlighted a need to centrally track NSP service closures as well as the extent to which naloxone is being distributed and to whom.

Government investment in harm reduction

Harm reduction is predominantly funded by the government in the UK, with the exception of some established harm reduction service providers supplementing their funding with small grants from donors such as Big Lottery and the Amy Winehouse Foundation. In 2013/14, budget decision-making for harm reduction and drug treatment in England and Wales shifted from national Government to local commissioning groups. These groups decide where to allocate public health funds for their area.

The metrics of success for drug services in England are centred on 'recovery' and becoming 'drug-free'. As a result, they are not rewarded for providing harm reduction but instead for helping clients to cease drug use and to reduce or end their OST prescriptions. In some areas commissioners have introduced a payment-by-results model with enhanced payment being given based on numbers of people exiting treatment 'drug free', ultimately leading to a focus on abstinence at the expense of harm reduction. Civil society reports that this makes it difficult for service providers to prioritise clients that are less likely to become drug-free as quickly or easily as others. There are also reports of clients being pressured to reduce OST dosages, to engage in other interventions in order to receive an OST prescription, and an overreliance on daily pick-ups even where clients had previously had take-home provision.[51]

NSP services have also been affected by recent funding cuts, with a number of drop-in sites closing and others being forced to streamline their services.[52] Provision is increasingly pharmacy-based in England. Pharmacies receive financial incentives to provide safer injecting kits, but they rarely offer a service comparable to that of a dedicated harm reduction site, where trained staff deliver advice tailored to client needs and provide referrals to other health, social and welfare services not offered on site. Standalone services that remain are streamlining their services in some areas, by way of reducing staff training, hiring staff on zero-hours contracts and reduced pay, and limiting the kits being distributed. At a time when harm reduction should be intensified to respond to the highest rates of drug-related deaths ever recorded in the UK, there is a disinvestment in harm reduction.[52]

Sustainability of harm reduction funding

Civil society anticipates further reductions in harm reduction funding in England in the coming years. In 2018, funding for harm reduction programmes will no longer be protected within local public health budgets, which could result in funding cuts in areas where local commissioning bodies do not prioritise these services. There is an increasing tendency for services to be delivered by third sector organisations competing for contracts through a tendering process. Civil society predicts that these factors will likely lead to reduced training and staffing levels and in the commodities and equipment provided, thus compromising the quality and capacity of those services still running. There is a fear that this will lead to rises in HIV and hepatitis C incidence among people who inject drugs, as well as an increased burden on emergency services. They highlight the need for stronger harm reduction advocacy in the UK to call for sustainable harm reduction services.[51, 52]

Ireland - A snapshot of harm reduction funding

Harm reduction coverage[ff]

People who inject drugs	6,289 (4,694–7,884)
NSP	No data available
OST	Likely high coverage, with 9,764 people receiving methadone in 2014
DCR	No DCRs yet, but a planned supervised injecting facility to open in 2017
Prison harm reduction	OST available in 11 out of 14 prisons, with a total of 524 prisoners on OST in 2013. No NSP in prisons
Take home naloxone	Pilot take-home naloxone project is underway

Transparency of spending data

While there is a mechanism in place to monitor national drug policy expenditure, costs relating to harm reduction interventions are not disaggregated from the wider labelled health spending. As NGOs provide most harm reduction services, usually alongside a wider array of drug services, it would require dedicated research to establish current spending on harm reduction.

> *'While NGOs are leaders in advocacy work, the way in which government departments and agencies present their budget figures makes it very difficult for NGOs to carry out detailed cost benefit analysis in relation to harm reduction services. NGOs do not generally have access to the levels of specialist expertise required to drill in to the detail of state funding and to carry out these financial calculations'* Anna Quigley, Citywide Drugs Crisis Campaign

Government investment in harm reduction

The Government Department of Health is the primary source of harm reduction funding in Ireland. There is no available estimate on government investment in NSP delivery. This investment has been supplemented by an Elton John AIDS Foundation of around €750,000 which has been used to facilitate the implementation of the national pharmacy needle and syringe programme since 2011, in partnership with the Government Health Service Executive.

Civil society estimates that Government spending on OST provision was approximately €19 million in 2014. The cost of OST provision per client is likely to be higher in Dublin than elsewhere in Ireland, reflecting higher levels of clinical support available in the city.[53]

The national drugs budget is determined at the national level and allocations to service providers are made at the local level by the Health Service Executive and through Drugs Task Forces. Civil society report that harm reduction and wider drugs services are not adequately funded, with austerity measures leading to budget cuts of up to 30% since 2008. EMCDDA report that drug-related expenditure overall has reduced by 16% since 2009.[54] These funding reductions have made it increasingly difficult to maintain existing service levels and to allow service providers to engage in essential harm reduction advocacy.[53]

It is not possible to establish what proportion of drug-related expenditure goes towards harm reduction initiatives in Ireland. In 2015, 51.7 % of the planned budget was allocated to activities falling with 'health' but this would have encompassed harm reduction alongside a wide range of other health interventions. Just over one-quarter of the budget was allocated for public order and safety, which would include drug law enforcement. In 2014, the total drug-related expenditure amounted to 0.12 % of gross domestic product in Ireland.

ff It was not possible to ascertain coverage levels of NSP in Ireland as data were not available.

Sustainability of harm reduction funding

National policy in Ireland includes a commitment to a public health approach to drugs and there has been a specific commitment from Government to provide for the introduction of a pilot supervised injecting facility in 2017. As a new National Drugs Strategy is currently being drafted, continued lobbying and campaigns will be necessary to ensure that plans come to fruition. Civil society-led campaigns have been at the forefront of harm reduction developments in Ireland, for example in securing legislative change to allow for supervised injecting facilities, and in the national expansion of NSP services.[53]

Belgium[gg] - A snapshot of harm reduction funding

Harm reduction coverage

People who inject drugs	25,295 (17,638–35,699)
NSP	Unknown because pharmacy NSP distribution figures not available, but national coverage likely to be moderate
OST	High coverage – 17,026 clients receiving OST in 2014, including some receiving heroin-assisted treatment
DCR	Not available
Prison harm reduction	OST available in prisons. No NSP available
Take home naloxone	No take-home naloxone programmes available, but civil society hoping to start one in 2017

Transparency of spending data

There are many challenges to establishing harm reduction investment in Belgium, both in the Flemish and French communities. Funding comes from both the national and regional budgets, and spend is not disaggregated in a manner conducive to tracking harm reduction spending.

Government investment in harm reduction

Harm reduction is fully government funded in Belgium but this funding comes from the national level and city-level budgets. Both in the Flemish and French parts of the country, NSP services are wholly funded by the respective government departments. In 2014, this investment was an estimated €560,000 within the Flemish part of the country.[55] There is no estimate available for the equivalent spending within the French part of Belgium. Across the country, funds come from both the national government and city-level investment which makes it challenging to gain a complete picture of national spending on harm reduction. In order to access funds for harm reduction delivery, NGOs must apply to the government with a proposal and budget. If granted and the project is established and is successful in achieving good results, NGOs may be able to access structural funding.

Across the country, OST is funded through social security. It is not free at the point of delivery, requiring clients to pay a charge for medication of around €3.50 per week. Civil society also reports that people regularly buy their own sterile injecting equipment, even where they have the option to access them for free from NSP sites, so some investment in harm reduction comes from people who use drugs themselves.

Civil society representatives report that there has been a slight increase in harm reduction investment in recent years, but that some gaps remain in the harm reduction response for which additional funding would be required. For example some parts of the country do not have adequate coverage of NSP services. Furthermore, there are not currently any NSP programmes within prisons in Belgium.

Sustainability of harm reduction funding

The biggest barrier for sustainable funding for harm reduction in Belgium is the moralistic view attached to drug use held by the majority of the public and government alike. This results in harm reduction not being as mainstream and accepted as it should be. The government favours abstinence over harm reduction, and law enforcement over support in its drug policy. This is reflected in the findings of an assessment of drug policy expenditure in 2012, which showed that harm reduction spending represented only 0.3%, treatment (including OST and abstinence based treatment) represented 29.9% and drug law enforcement an overwhelming 68.8% of national drug policy spending. Overall, drug policy expenditure represented 0.16 % of gross domestic product (GDP) in 2012.[56]

gg HRI received a civil society survey response on the Flemish community in Belgium, not the French community or the German community and this is reflected in this section.

Civil society in the country reports that funding for harm reduction is sustainable in the short term with funding levels likely to remain at existing levels for NSP and OST. They report however that the government is less likely to fund new and innovative harm reduction approaches.

In 2015, an initiative to support people who use drugs that have tested positive for hepatitis C and either wish to access treatment or are currently receiving treatment began in Antwerp. Known as the 'CBuddy peer project', this was originally funded by pharmaceutical companies, but in early 2017 the Flemish government began to cover the costs of this initiative.[55]

Civil society organisations have a strong history of harm reduction advocacy in Belgium, but they are not currently involved in advocacy on harm reduction funding and note that there is a need for increased capacity in this area.

France - A snapshot of harm reduction funding

Harm reduction coverage

People who inject drugs	122,000
NSP	Likely high coverage – 583 sites with estimated 90,000 people using them
OST	High coverage, 161,388 clients were prescribed OST in 2014
DCR	One DCR in Paris and one in Strasbourg
Prison harm reduction	OST available in all prisons. No NSP in prisons
Take home naloxone	No national programme. Limited to prescription by a doctor only

Transparency of spending data

Some spending information on harm reduction is publicly available in France. For example, civil society were able to access estimates of national spending on NSP and OST programmes. The biggest challenge in gathering data on harm reduction is to disaggregate funds that have been allocated to addictology centres, which provide a range of drug-related services, to have a clear sense of the budget specifically dedicated to harm reduction activities.[57]

Government investment in harm reduction

A three-year National Drug Action plan and associated budget determines part of the funding allocations for harm reduction funding in France. The social security system provides a stable source of funding for harm reduction which covers 80% of NSP delivery and 90% of costs involved in OST provision. At the local level, Regional Health Agencies determine how to distribute allocations to service providers. The remaining funding for harm reduction is covered by local public entities such as regional councils and municipalities. This funding usually covers specific programmes such as outreach in rural areas or safer nightlife interventions.

Civil society report that €200-230 million was spent on harm reduction measures in 2014. This figure includes €32 million for low threshold drop-in centres, €150 million for OST (including consultation, medicine and structural costs) and €45 million for NSP (including outreach).[58] The new drug consumption room that opened in late 2016 in Paris has a budget of €1 million per year, which will be covered entirely by the social security system. According to civil society, funding for harm reduction increased between 2010-2014, with extra monies covering increases in the number of drop-in centres and NSP sites. In their view, government support for these programmes was forthcoming as a result of the positive impact of these programmes in reducing drug-related deaths and reducing HIV infections among people who inject drugs. Unlike several other countries in the European Union, it is reported that out-of-pocket harm reduction expenses by people using drugs are minimal, as most services and commodities are available free of charge.

Interestingly, in France one-tenth of money coming from police seizures is allocated to drug prevention and care, which includes harm reduction. This is coordinated by the Inter-ministerial Mission of Drugs and Addictive Behaviours, which makes allocations to programmes directly. In 2016, it is reported that in total this amounted to €1.14 million but it is not clear what proportion was allocated to harm reduction programmes.[57]

EMCCDA report that total drug-related expenditure in 2013 was equivalent to 0.1 % of gross domestic product (approximately €2 billion). Of this, the majority (44.6%) went to health activities and social protection, while 28.6% went towards public order and safety with the rest going to education, drug-related defence initiatives and general public services.[59]

Sustainability of harm reduction funding

Civil society are optimistic that the government has the ability and willingness to sustain harm reduction funding levels in the next five years but they note that this will depend on the incoming government's approach to drugs.[57] Already there are plans to implement further DCRs in France as part of a six year trial. There are also plans for a new 'take-home naloxone' programme for which funding is expected to be secure.

Harm reduction advocacy is strong in France, with NGOs and associations working in partnership to call for change. This has included advocacy for the establishment of a DCR, and ongoing efforts to allow hepatitis C treatment to be covered by social security funding. They note that a major focus of their advocacy is simply ensuring that policies and plans made by decision-makers are adequately funded and implemented, so that 'acts and budgets follow words'.[57] However, ideology and the repressive drug laws and policies continue to hamper advocacy efforts. For example, the law criminalising the use and promotion of use of drugs was a barrier to the government agreeing to fund the DCR.[57]

> ***'Harm reduction will not be completely effective as long as we keep repressing rather than regulating drug use'.*** Laurene Collard, Federation Addiction, France

Germany - A snapshot of harm reduction funding

Harm reduction coverage

People who inject drugs	94,250 (56,000–169,500)
NSP	Likely high coverage, particularly in the North and West of the country
OST	High coverage – 77,500 clients in 2014
DCR	24 DCRs operating in 15 cities
Prison harm reduction	OST available to prisoners but currently reaches only 10-15% of those who could benefit from it. One women's prison has NSP
Take home naloxone	No take-home naloxone programmes available

Transparency of spending data

There is no central collection of spending information on any aspect of harm reduction programming in Germany. To gain insight into national expenditure, this would need to be tracked at the state, or Länder (local district) level and collated. This would also apply to collecting spending information on harm reduction in prisons, which again falls under the responsibility of the Länder.

Government investment in harm reduction

Harm reduction in Germany is wholly funded by the government at the state and municipal level, which is also where decision-making on funding allocations occurs. Harm reduction funding is reported to have reduced between 2010-2014, as reduced allocations have been made available to municipalities and Länder. This is reported to be due to competing government priorities and obligations, for example, costs relating to the German response to the refugee crisis. As in other countries, civil society are the main providers of harm reduction services and they receive funds from the Länder to implement services.

While no information is readily accessible on drug law enforcement spending, a study of the EMCDDA's Reitox Focal Point in Germany some years ago reported the ratio between 'Repression – Help' to be 7:3.[60]

Sustainability of harm reduction funding

The German government has a long history of supporting harm reduction domestically and overseas via the German Society for International Cooperation (GIZ). Civil society report that the government is likely to have the capacity and political will to sustain their investment in harm reduction for the next five years.

The Netherlands - A snapshot of harm reduction funding

Harm reduction coverage

People who inject drugs	2,390 (2,336–2,444)
NSP	High coverage – 175 sites
OST	High coverage, with 7,569 people receiving methadone and 697 receiving heroin assisted treatment in 2014. No estimate for the number of people receiving buprenorphine
DCR	31 DCRs each seeing about 50 visitors per day
Prison harm reduction	OST available in all prisons. No NSP in prisons
Take home naloxone	May be available from one or two DCRs, but no nationwide programme in place

Transparency of spending data

Isolating spending related to harm reduction in the Netherlands would be an extremely difficult task, as harm reduction funding is embedded in federal budgets, research budgets, municipal budgets as well as being covered by health insurance. NSP, for example, is included in municipal budgets, whereas OST is covered by health insurance. While national civil society recognised the value that tracking this information would bring, they highlighted that it would be challenging.

Government investment in harm reduction

Civil society respondents were unable to provide any information on the financial investment of the government into harm reduction in the Netherlands, for reasons outlined above. However, they note that the level of funding has remained stable in recent years and quality and coverage of harm reduction services is sufficient.[61, 62]

In 2003, it was estimated that harm reduction represented 10% of drug-related expenditure in the Netherlands and with three-quarters of overall spending attributed to law enforcement. Treatment (including OST) and prevention were allocated 13% and 2% respectively. Overall, drug-related expenditure at the time of the study represented 0.5% of gross domestic product in the Netherlands.[63]

Sustainability of harm reduction funding

Harm reduction remains an integral part of Dutch national and international drug policy, and as such, it is anticipated that funding for harm reduction will continue at current levels for the foreseeable future.[62] However, is it noted that spending in relation to public health care in general is under pressure. Consistently high coverage of harm reduction programmes for several decades has been credited for the low rates of drug-related harms in the country. As a result, responding to drug use is no longer an urgent political priority, therefore on-going advocacy to serve as a reminder of the benefits of a public health response to drugs will continue to be necessary.[61]

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Europe is the birthplace of harm reduction, and the region where the successes of this approach in averting epidemics can be most plainly seen. It includes harm reduction champion countries, that have long invested in their national harm reduction programmes and implement a wide array of interventions. However, austerity, international donor retreat and poor political support are severely limiting harm reduction responses in several countries in the EU. In some states, there is a funding crisis for harm reduction which must be addressed if public health emergencies are to be avoided.

This report summarises research findings from Harm Reduction Works!, providing a snapshot of harm reduction investment in eighteen EU member states. It includes findings from spend tracking research in the Czech Republic, Greece, Italy, Estonia, Portugal, Hungary and Lithuania. Using a simple traffic light system, countries are categorised as either red, amber or green on four criterion, providing an at-a-glance indication of the health of harm reduction funding in a country. The report provides recommended actions to increase the sustainability of harm reduction funding within the European Union.

Harm Reduction International is an international non-governmental organisation that works to reduce drug-related harms by promoting evidence-based public health policy and practices, and human rights based approaches to drug policy through an integrated programme of research, analysis, advocacy and civil society strengthening. Our vision is a world in which individuals and communities benefit from drug laws, policies and practices that promote health, dignity and human rights.

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